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CONTENTS.

ORIGINAL PAPERS.

1.—Shortening of the Lower Limb after Fracture of the Femur. By Jarvis S. Wight, M. D., of Brooklyn, ... 283
2.—Fibro-Cystic Tumor of the Neck. By Robert Battey, M. D., of Rome, Geo., ... 293
3.—Radical Cure of Strangulated Inguinal Hernia. By Isaac Smith, Jr., of Fall River, Mass., . . 299

PROGRESS OF SURGERY.

Report on Syphilis and Venereal Diseases. By Robert W. Taylor, M. D, ... 300

HOSPITAL RECORDS.

PENNSYLVANIA HOSPITAL, PHILADELPHIA—REPORTED BY JOHN B. ROBERTS, M. D.

Excision of the Rectum for Carcinoma. Service of Dr. R. J. Levis, ... 311

COLORED HOSPITAL, NEW YORK—REPORTED BY WILLIAM KELLEY, M. D.

Extirpation of the Rectum for Carcinoma. Service of Dr. C. K. Briddon, ... 312

CORRESPONDENCE.

Observations Upon a Criticism. By John A. Wyeth, M. D., of New York, ... 31

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ARCHIVES
OF
CLINICAL SURGERY.

VOL. I, FEBRUARY, 1877. NO. 8.

ORIGINAL PAPERS.

SHORTENING OF THE LOWER LIMB
AFTER
FRACTURE OF THE FEMUR.

A LECTURE BY

JARVIS S. WIGHT, M. D.,

Professor of Surgery and Clinical Surgery at the Long Island College Hospital.

GENTLEMEN—To-day I propose to talk to you about the nature and cause of the lower limb being *shortened* after treatment of fracture of the femur. You have seen a number of cases of fracture of the femur as they have been brought to the hospital in the ambulance; you have examined these cases before reduction of the fragments of bone; you have noted the difference in length of the injured limb before and after reduction; you have watched the treatment from the beginning to the end; and you know that sometimes the injured limb has been left, after treatment, shorter than the other. But did it ever occur to you, that our standard of comparison has always been the uninjured limb? We have in every case measured the sound limb; and then we have measured the injured limb; and thereupon we have noted the difference. Seeing that the injured limb is quite often shorter than the other, you may have asked, *Can we obviate shortening of the lower limb after fracture of the femur?* Let me tell you that there is great diversity of opinion on this point of *shortening*. And let me add, that experts differ in their measurements of limbs—not very materially to be sure, but they differ. And one expert will sometimes have various differences in succession, after several comparative measurements of two limbs. And yet, with care, he will arrive at an actual difference in the length of any two limbs which are not of the same length, and be able to fix very nearly what that difference is.

And now, before going further into our subject, let us review the general structure of the thigh :—Begin with the fascia lata at the coccyx, sacrum, crest of the ilium, and Poupart's ligament, remembering the connection with the superficial fascia; trace the fascia lata till it runs into the structure of the leg; see how strong an investment it sends to the gluteus medius; note its conjunction with the triceps rotator — that is, the internal obturator and the gemelli; remember the two strong inter-muscular septa as they go in and are attached to the linea aspera; consider the periosteum and the articular capsule in their genetic relations, not forgetting the ilio-femoral ligament; recall the general fact, that all this fascia is connective tissue; then try to get a clear conception of the ramifications of this tissue in every part of the os femoris :—And now look upon this fascia, this connective tissue, this expansion and ramification of structure, as the real skeleton of the thigh, in which are put bone-substance for support and locomotion; muscle-substance for contraction and motion; nerve-substance for conduction of impressions and impulses; tubes and spaces for conveying blood and lymph, and living cells for the continuation of nutrition; and you will have a consistent idea of the structure and the function of the thigh.

After many years, in which there has been much discussion, and some contention, about the broken os femoris, it has occurred to me to measure the lower limbs of those who have never had the femur broken. The measurements were made from the most prominent point of the anterior superior spine of the ilium, to the lower extremity of the internal malleolus. In measuring, I use the tape-line with the figures down, so that I cannot see them; then I note the figures indicating the length of the limb; now I let go my hold of the tape-line, and seize it again at random, still having the figures so that I cannot see them; and then I measure the other limb, noting the difference in length, if any; and it is judicious to repeat this process several times, so as to eliminate, as far as possible, any error. This is my usual practice in cases of fracture: and I have measured sound lower limbs in the same manner. The following table will show the comparative measurements I have made of normal lower limbs of males. I have not included the measurement of the cadavers and skeletons, for it would be quite impossible to know surely, that a cadaver had not a united fracture, which might be concealed by the soft parts; and a doubt could reasonably arise in regard to the bones of a skeleton—did they come from the same subject?

In making these comparative measurements, I have simply tried to get at the truth; and if the truth gives us, as surgeons, more uncertainty in our practice, that is not my fault. Yet, it must be, that the truth will, in more ways than one, come to be advantageous to all parties concerned.

No.	AGE.	OCCUPATION.	NATIVITY.	Length in Inches.		Difference.
				R. Limb,	L. Limb.	
1.	32,	Clerk,	Canada,	33¾,	33½,	¼, R.
2.	22,	Nurse,	United States,	31¾,	31¼,	½, R.
3.	24,	Clerk,	England,	33,	33.	
4.	47,	Carpenter,	Germany,	32½,	32¾,	¼, L.
5.	18,	Sailor,	Germany,	35,	35½,	½, L.
6.	24,	Sailor,	Norway,	34,	33⅝,	⅜, R.
7.	30,	Sailor,	United States,	32¾,	33¼,	½, L.
8.	19,	Sailor,	Norway,	30,	30½,	½, L.
9.	28,	Sailor,	Scotland,	31,	31½,	½, L.
10.	27,	Sailor,	Negro, W. I.,	35,	35½,	½, L.
11.	44,	Nurse,	Holland,	31,	32⅜,	1⅜, L.
12	14,	School Boy,	Ireland,	31¼,	31¼.	
13.	44,	Laborer,	Ireland,	34½,	35,	½, L.
14.	37,	Laborer,	Ireland,	33¾,	34¾,	1, L.
15.	12,	School Boy,	United States,	30½,	30¾,	¼, L.
16.	14,	Sailor,	United States,	31¼,	31,	¼, R.
17.	25,	Sailor,	Colored, U. S.,	31¼,	31,	¼, R.
18.	34,	Sailor,	Italy,	32,	32½,	½. L.
19.	21,	Sailor,	Norway,	30½.	30½.	
20.	19,	Sailor,	United States.	34⅛,	33¾,	⅜, R.
21.	24,	Sailor,	Nova Scotia,	35¾,	36⅛,	⅜, L.
22.	40,	Sailor,	England,	34½,	34½.	
23.	32,	Sailor,	New Brunswick,	34½,	34¼,	¼, R.
24.	28,	Sailor,	United States,	34½,	34,	½, R.
25.	25,	Sailor,	United States,	32,	32.	
26.	22,	Sailor,	England,	34½,	34¾,	¼, L.

No.	Age.	Occupation.	Nativity.	Length in Inches.		Difference.	
				R. Limb,	L. Limb.		
27.	22,	Sailor,	United States,	35,	35.		
28.	31,	Sailor,	Norway,	31½,	32,	½,	L.
29.	19,	Sailor,	Sweden,	35,	35.		
30.	23,	Sailor,	Finland,	32⅛,	32¼,	⅛,	L.
31.	20,	Sailor,	Austria,	33,	32¾,	¼,	R.
32.	29,	Sailor,	United States,	34,	34¼,	¼,	L.
33.	21,	Sailor,	Dalmatia,	34½,	34¼,	¼,	R.
34.	37,	Janitor,	Ireland,	32,	32½,	½,	L.
35.	33,	Messenger,	Scotland,	33½,	34,	½,	L.
36.	24,	Mechanic,	United States,	32½,	32¼,	¼,	R.
37.	32,	Laborer,	United States,	31¼,	31,	¼,	R.
38.	32,	Salesman,	Ireland,	33⅛,	33,	⅛,	R.
39	58,	Laborer,	Ireland,	34¼,	34½,	¼,	L.
40.	30,	Plumber,	Ireland,	32,	32¼,	¼,	L.
41.	12,	School Boy,	United States,	27½,	27½.		
42.	35,	Peddler,	Ireland,	32⅞,	33,	⅛,	L.
43.	14,	None,	United States,	30½,	30,	½,	R.
44.	36,	Laborer,	Ireland,	31½,	31¼,	¼,	R.
45.	39,	Salesman,	Ireland,	31¼,	31½,	¼,	L.
46.	30,	Laborer,	Ireland,	32¾,	32½,	¼,	R.
47.	24,	Laborer,	Ireland,	34⅞,	35¼,	⅜,	L.
48.	33,	Sailor,	Austria,	33½,	33¼,	¼,	R.
49.	29,	Clerk,	Ireland,	36,	36.		
50.	40,	Laborer,	Ireland,	34¼,	34½,	¼,	L.
51.	56,	Laborer,	Ireland,	32¾,	32¾.		
52.	44,	Laborer,	Germany,	31½,	31⅝,	⅛,	L.
53.	41,	Druggist,	United States,	36,	36¼,	¼,	L.
54.	20,	Sailor,	Denmark,	34¼,	34½,	¼,	L.
55.	18,	Sailor,	Germany,	34,	34¼,	¼,	L.
56.	21,	Sailor,	Germany,	33¾,	34,	¼,	L.
57.	24,	Sailor,	Austria,	36½,	36¾,	¼,	L.
58.	26,	Sailor,	Ireland,	33¼,	33,	¼,	R.
59.	26,	Sailor,	Finland,	31¼,	32⅛,	⅞,	L.
60.	29,	Sailor,	Italy,	30⅛,	29¾,	⅝,	L.

My investigations, of which the above table is a specimen, and my practical observations, give support to the following conclusions: *First*—The lower limbs of the same person are not always of the same length, if they are measured in the way above described.

Secondly—The greater number of lower limbs, comparing the limbs of the same person, show a difference in length.

Thirdly—The normal lower limbs that I have measured give the following result: The left lower limb is oftener longer than the right lower limb, and the right lower limb is nearly as often longer than the left lower limb.

Fourthly—About one person out of every five has lower limbs that measure the same length.

Fifthly—The difference in the length of normal lower limbs of the same person, varies in different cases—from one-eighth of an inch to one inch. I have considered every difference less than one-eighth of an inch as no difference. And I found one case, in which the left limb measured one inch and three-eighths of an inch longer than the right limb; of course I recognize the extreme difficulty of making exact measurements of normal limbs; but the same difficulty supervenes to perplex the measurements of lower limbs, one of which has a broken femur; and if it is proper and justifiable to make comparative measurements of broken bones, before and after union, it is admissible to make comparative measurements of unbroken bones. The facts are as reliable in one case as in the other.

Sixthly—I have measured the lower limbs of cadavers and of skeletons, the soft parts having been removed by dissection. These measurements confirm the above results.

It is admitted that the length of the long bones depends on the epiphyseal cartilage; that is, the cartilage ossifies, and adds to the length of the shaft, and the cartilage continues to grow at the same time, until the individual arrives at a certain age, when the development is complete. And it is easy to understand why one epiphyseal cartilage may grow somewhat more rapidly than another, or one of these cartilages might continue to grow and ossify after the other had completed its development; so that it is not difficult to explain why there may, in some cases, be a difference in the normal length of the lower limbs.

And it might be, that the normal lower limbs in a given case were of equal length, and that the measurements would give different lengths, on account of one malleolus extending downwards a little further comparatively; or because the most prominent projections of the anterior superior spines of the ilium occupy comparatively different positions; one projection being a little further down, and the other projection being a little further up, on the curvature of the spine of the ilium; yet these are the points usually selected for measurements, in detecting shortening after fracture of the femur; and if they are to be taken as landmarks when the femur is broken, they may be taken as landmarks when the femur has not been broken. And if it is difficult to measure exactly an injured limb, it is just as difficult to measure exactly an uninjured limb.

Other corresponding bones in the body sometimes vary in length; notably for instance, the clavicles; for the right clavicle is often shorter than the left, especially in workingmen. And this fact must be considered, when the surgeon is called upon to treat a fracture of the clavicle, so that if the right clavicle be fractured, and after union it be found a little shorter than the left, the shortening could not certainly be attributed to difficulty or to neglect in treatment, for it may have been originally shorter. And in a case where a surgeon was sued for malpractice, I testified before the court, the right clavicle being in question, that the broken bone was probably a very little shorter than the corresponding one, because it had been shorter before the injury, since the treatment had been most thorough, giving an excellent result. The plaintiff was a day-laborer.

If my investigations and observations are correct:

I.—To assume an equality in the normal length of the lower limbs of a patient who has a broken femur, would, in many cases, involve an error of more or less gravity. In other words, it would be quite impossible to say, from the most careful measurements, how much a broken femur had shortened a limb, if the uninjured limb is made the standard of comparison. And a correct and reliable conclusion could only be reached in a case, in which the injured limb had been measured *before* and *after* the injury. There are more chances against than for an assumption of an equality of length in the lower limbs of any one case.

II.—Suppose a case: A man's left lower limb measures one inch longer than his right lower limb, and he has never been injured. Let him fall and break his right femur. It would certainly be very unscientific, unskillful, and perilous to apply extension and counter extension so forcibly as to make the injured limb as long as the other. Having in mind the great strength and resistance of the fascia of the thigh, I must say that in such a case, such extension would be impossible; and if it were possible, it would be unjustifiable. Or let him break his left femur A moderate degree of extension and counter-extension, would make the injured limb as long as the other, and readily keep it as long. Such cases as this are quite often met in one's surgical experience. Circumstances sometime favor the surgeon, but they are quite as often against him. We get credit when we deserve it least, we get blame when we deserve most praise; and such is the profession which you have chosen.

III.—Practically, in some cases of fracture of the femur, I have easily made the injured limb as long as the other, and have supposed the good result to be partly due to skill in treatment. In other cases, I have found it absolutely impossible, by any justifiable means, to prevent as much as an inch shortening. Cases of extreme shortening after fracture of the femur have not fallen to my lot. A specimen of very great shortening of a broken femur, with firm union, you will find in the museum of the college. Now, I have often accused the muscles and fascia for interfering with my attempts to obtain perfect results. Why, the femur is playing the trick of evolution, it varies in length!

IV.—I have always held, that, in a certain number of cases of fracture of the femur, shortening will occur after any treatment, and have so testified before legal tribunals, usually putting the average shortening, when shortening takes place, at about one inch: and I must now add to the accidental and the ordinary causes of shortening in cases of fracture of the femur, an important one, namely, a quite common inequality in the length of the lower limbs whose bones have never been broken.

V.—If these results are based on sound observation, they affect materially suits at law for malpractice; for, if a patient has had a fracture of the femur, and the corresponding limb be an inch or more shorter than the other after treatment; and if the patient feels himself aggrieved and sues his surgeon, on account of the apparently unusual shortening; and if it can be shown, that, in a considerable number of cases, lower limbs whose femora have not been broken are not of equal length, then the surgeon has a good cause; in fact, he is unquestionably armed with a strong defence over and above his having used all due diligence in the care of his patient. Because, no surgeon can be expected to repair a broken bone, so that it will be more perfect than it was originally. And I need not tell you, that these facts bear heavily on any one who may claim the skill and the ability to prevent shortening, in the treatment of all cases of fracture of the femur; and who may boast of having so applied the art of setting broken bones, that he has actually made the broken bone longer than the corresponding unbroken one. In fact, I have treated two cases of fracture of the femur, occurring within two days of each other; the patients were put in beds, side by side; one was a boy, the other was an adult; the adult had the minimum of surgical attention, and recovered with lower limbs of the same length; the boy had the maximum of surgical attention, and after union of the fragments of bone, the injured limb was one inch shorter than the other. Let me add, that the extending weight for the boy, was half as heavy again as that for the adult.

I will here give a brief account of two cases; one having fracture of the right femur, and the other having fracture of the left femur. These two cases are now in the hospital, under the care of one of my colleagues.

Case I.—Laborer, aet. 29, nativity, United States, broke his right femur about the lower part of the middle third. The patient was etherized, the limb was drawn down as far as possible, splints were adjusted, and an extending weight applied to the foot. Then the limb was found to be one inch shorter than the other. Thirty seven days after the injury, an extending weight of sixteen pounds still applied, the patient's right limb measured three-fourths of an inch shorter than his left limb.

Case II.—Laborer, aet. 35, nativity, Ireland, broke his left femur obliquely about the middle. This patient was put in a bed by the side of the previous patient, and the only difference in the surgical appliances, was an extending weight of twelve pounds for the second patient, and one of sixteen pounds for the first patient. The left limb of Case II measured one-half inch longer than the right.

Now one cannot help remarking here, that, probably, case number one had, before his injury, a right limb shorter than his left one; for very great efforts were made to make the injured limb as long as the the other, but they were impotent. And it is very probable, that case number two had a left lower limb longer than his right one before the femur was broken. At any rate, the normal inequality of the lower limbs aids very materially in giving a satisfactory explanation of the marked difference in the two cases we have just described.

I now recall obscure and perplexing injuries to the hip, that have, from time to time, come under my observation. And I explained these cases in one way or another, fortifying my opinions by the authority of our best authors. Specimens of these cases will interest and instruct us now:—(*a.*) A man fell on his left hip, and some years after came to my clinic. The limb on the injured side was three-fourths of an inch shorter than the other; there was no history of fracture of the neck of the femur; indeed, the injury had been insignificant. And so I explained the case by saying that the bone had been absorbed. A transverse slice of the bone where the impact of the fall came, had disappeared; and the scientific designation of this is *interstitial absorption*. Ah! Gentlemen, perhaps that femur was like the poet—*born so*, and grew so. Who knows?

(*b.*) Another man was brought to my clinic last session; he had fallen on his right hip. The limb was somewhat everted; it was about one-half inch shorter than the left limb; there was no crepitus. An impacted fracture of the neck of the femur was suspected and the appropriate treatment for such a fracture was employed; the injury was so slight that I soon discontinued the treatment and no harm came to the patient. Interstitial absorption of bone is a comparatively slow process, so that is out of the question; and the presumption is that the limb was the same length before and after the fall. And the action of the many strong muscles that rotate the thigh outward was the cause of the eversion.

(*c.*) I have recently been present at the post-mortem examination of a patient who died suddenly. About four weeks before his death he had an oblique fracture of both bones of his left leg, at the junction of lower and middle thirds; the union of the tibia was found to be quite firm, but the fibula had not yet united. A careful comparative measurement of both legs gave the one that had been fractured one-half inch shorter than the other; and a careful measurement of both limbs made them as equal as possible. If the fragments united without shortening, the leg was originally shorter than the other; and if the broken leg was shortened, then the left limb was originally longer than the right.

Hence, we are entitled to make the following practical conclusions:

1. We need not expect in all cases of fracture of the femur to give the patient lower limbs of equal length. In other words we cannot always prevent the so-called *shortening:* the number of shortened limbs cannot be accurately fixed.

2. In a certain number of cases of fracture of the femur the injured limb will remain shorter than the other—no matter what the treatment may have been.

3. Excessive efforts persisted in to bring the injured limb down and make it as long as the uninjured one will sometimes fail, and are calculated to do harm; since the strong fascia of the thigh offers great

resistance, and since the injured limb may have been shorter than the other before the injury.

4. If need be, complete relaxation of the powerful muscles of the thigh by etherization will enable an ordinary and admissible degree of extension and counter-extension to give the injured limb a maximum length: or extending weights gradually applied will "tire out" the muscles; at first apply four pounds, then add to that four more pounds, then make the weight twelve pounds, now increase the extension to sixteen pounds, and in some instances make the extending weight twenty pounds, removing a certain part of the extension as may be considered necessary.

5. The possibility of having the injured limb longer after treatment than the other must be recognized, and the most probable explanation of such a result must be given.

6. These conclusions conform to the practice and agree with the results of the best surgeons.

Finally, perhaps I ought to add, that the variation in the length and obliquity of the neck of the femur, incident to the age of the patient, may not occur during the same time and with equal pace in the femoral necks, and that this may be one cause in some instances of a difference in the normal lengths of lower limbs. At any rate it may be noted that there is a remarkable approach to an agreement between the differences in the length of normal lower limbs, and the difference in length of lower limbs—one of which has had the femur broken: only the average difference is somewhat greater in case there has been a fracture of the femur. But in general, the tendency of a fracture of the femur is to shorten the limb to which it belongs. And we may fairly regard assertions of always having lower limbs of equal length, after treating fracture of the femur, as open to just criticism. Such assertions are calculated to put individual surgeons in peril of suits at law for malpractice when they do not deserve it; and they are, if found to be untrue, a sure means of throwing discredit on a useful and an honorable profession.

Dr. W. C. Cox a few years ago accurately measured the normal lower limbs of fifty-four cases, and found only six whose lower limbs were of equal length; the rest varied in length; the smallest difference was one-eighth of an inch, and the greatest difference in length was seven-eighths of an inch; while fifteen cases showed a difference of half an inch or more. It will be seen that my investigations substantiate those of Dr. W. C. Cox.—See ARCHIVES, page 237.—*American Journal of the Medical Sciences*, April, 1875.

FIBRO-CYSTIC TUMOR OF THE NECK,

BY

ROBERT BATTEY, M. D.,

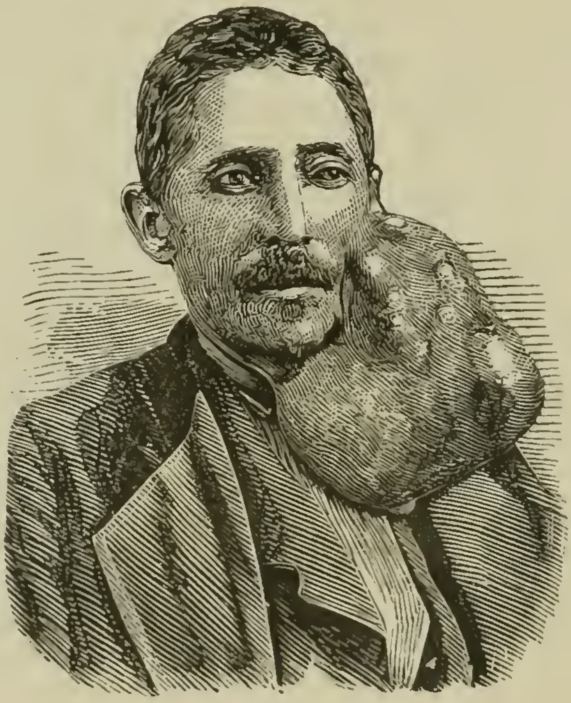
ROME, GA.

◆

Mr. Colman Keen, of Walnut Hills, LaFayette County, Arkansas; a native of Washington County, Ga., aet. 43; weight 145 pounds; race, Caucasian; occupation, farmer; physique, tough and wirey; tissues like good old bacon, firm and dry; married, father of seven children; always enjoyed good health, and still able to do effective labor on the farm, notwithstanding his grievous burden, of which he seeks relief. His father died at the age of 45, of typhoid fever; his mother at 40, with general dropsy.

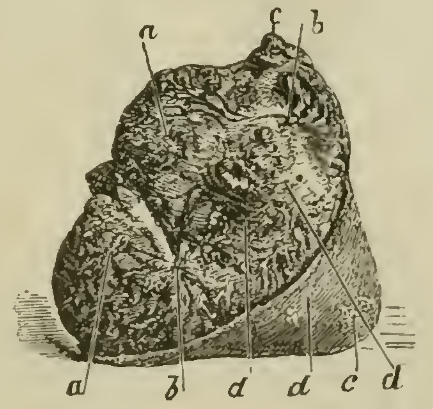
Sixteen years ago, he observed a small tumor developing beneath the jaw, in the region of the left submaxillary gland. It gave him no pain, grew slowly, and did not command much of his attention for some years. It was hard, and quite movable. As the tumor enlarged, it progressed both upwards towards the ear, and downwards along the anterior margin of the sterno-cleido muscle. For several years past it has increased in a much more rapid way, and has become soft at a number of points upon its surface. During the past twelve months, the augmentation in bulk had become so rapid as to alarm his fears, and add seriously to his burden.

On examination, I found the large irregular tumor, illustrated in Cut I. It was moderately movable in a direction upwards and downwards, and much more freely so in the direction forwards and backwards. Above, it had involved the lobule of the left ear, and completely closed the external meatus, depriving him for the time of the sense of hearing upon the left side. In a forward and upward direction it had surmounted the lower jaw, and formed a broad and firm attachment to the zygomatic arch and superior maxillary bone, by which the weight of the tumor was chiefly supported. Below, it had burrowed its way downwards and forwards, until it passed the median line and rested upon the trachea and sternum. Behind and below, the base of the tumor reached to the clavicle, and the pendulous portion hung down upon the chest, as shown in the cut. Its surface throughout was irregular and nodular, soft and elastic rather than fluctuating in some of its parts; in others, quite hard and resisting to the touch. So completely were the carotid vessels covered in by the tumor, it was impracticable to feel the arterial pulsation at any point. The superficial veins were not enlarged; the course of the external jugular could not be traced at all. The skin was not actually adherent at any point, and yet it did not move with freedom over the tumor. From the history and external characteristics of the growth, a diagnosis of fibro-cystic tumor of the neck was unhesitatingly made, without resort to the exploring needle, which was deemed unneccessary.



Cut I.

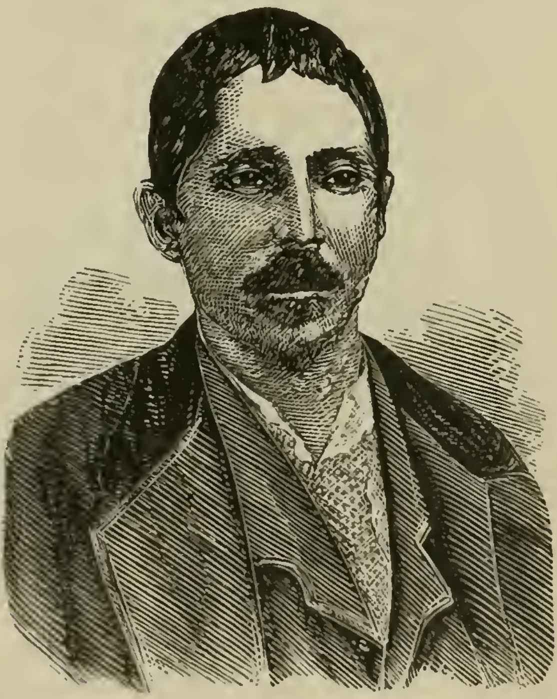
With a rest of but a single day from his journey, and without any attempt at systemic preparation, he was subjected to operation on the eleventh of November last, my partner, Dr. G. W. Holmes, and Drs. T. J. Word, and A. P. Richardson kindly assisting me. The patient having been fully etherized, a large anterior flap (see Cut II) was reflected upwards upon the face and anterior surface of the neck, and a correspondingly large posterior flap was turned down over the chest and shoulder. These flaps were purposely left of ample size, to provide for much shrinkage, and to avoid any tension in the sub-maxillary fossa. The formation of the flaps required slow and tedious work, as the connections between the tumor and the adjacent tissues were very firm and intimate, and the vessels, though for the most part of small calibre, were quite numerous, ten or twelve ligatures being required, besides torsion of a number of others. Each vessel was dealt with in turn as it was severed. The external jugular was found to pass through the centre of the tumor, and it was ligatured and divided upon either side, a double ligature being used in each case. Care was used in the dissection to keep fully down upon the tumor, and to follow closely the line of demarcation between it and the surrounding textures, thus avoiding confusion and uncertainty, and enabling me to enucleate the tumor cleanly and completely, as will be seen in the photograph from which Cut II is taken. Fortunately, the deeper portions of the growth which lay upon the parotid gland and dipped down rather deeply in the carotid space, did not involve either of those large vessels, the internal jugular vein, nor the pneumogastric, phrenic, or other important nerve. Notwithstanding the great precautions taken to avoid any unneccessary hemorrhage, the operation was a bloody one, as such operations upon the neck usually are. That it should have been so, is not surprising, when it is stated that the raw surface exposed on lifting out the tumor could not have been fully covered by a dinner-plate. Upon the completion of the operation, the pulse was still fairly good, notwithstanding the very considerable loss by oozing of the surfaces. The flaps, with a single slight trimming at the upper angle, were brought together in a line connecting the ear with the top of the sternum, in such manner as to hide the cicatrix in the cervico-maxillary fossa, and were united by



Cut II.

numerous points of silk suture. At the upper angle, the loose skin was utilized, by folding in such manner as to reproduce the lobule of the left ear very perfectly. The submaxillary space was well filled up with soft sponges, as recommended by Gross, surmounted by compress and bandage, to keep the flaps well in contact with the subjacent tissues. This arrangement was found to work admirably, and as I think the event showed, with great advantage to the patient.

The patient rallied well from the operation, was cheerful and comfortable, requiring no morphine until night, when a single dose secured good rest. At 6 P. M., the pulse was 120, the temperature 99.7°; at 9 P. M. the figures fell to 96 for the pulse, and 99° for the temperature. On the morning of the second day, the pulse was 120, temperature 101°, and in the evening, pulse 130, temperature 103°. At night, twelve grains of quinine were given, but, as the stomach rejected it, no more was attempted. On the third day morning, the pulse and temperature had dropped to 96 and 100.5° respectively. The dressings were now removed for the first time, and the lips of the long wound appeared well adherent throughout. A grain and a-half of saccharine calomel* was placed upon the tongue, with a view to



Cut III.

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* See *Atlanta Medical and Surgical Journal* for August, 1873, p. 261.

move the bowels. From this time forwards, there was no considerable rise in either pulse or temperature, and everything progressed as favorably as could be asked. The bowels moved satisfactorily on the fourth day. Upon the fifth day, he called for food and sat up in a chair. On the seventh day he got on his clothes, and sat up most of the day. He was on his usual diet, and the appetite was sharp. On the twelfth day, most of the ligatures came away, and he was out upon the street. Thirteenth day the last ligature came away; upon the street several hours. Fifteenth day, photograph taken, (see Cut III,) discharged to visit friends in Alabama. The wound was now healed, excepting at two points, either of which might be covered by the tip of the finger. In three days more I saw him upon the cars, en route for his home in Arkansas, in fine health and spirits, duly thankful for his riddance from the burdensome load which had caused him to take so long a journey. On the twenty-sixth of December he writes, that soon after his return home, a small abcess formed behind the angle of the jaw, which discharged itself, since which he has been entirely well.

The tumor removed (Cut II,) weighed four and a-half pounds. In general appearance it reminded me strikingly of a fibro-cyst of the ovary which I had formerly removed from the abdomen, with the single exception that the cyst walls were very much more thin and delicate, in the case under consideration. It consisted of a dense, fibrous portion, in which were bedded numerous small cysts, and which was surrounded by quite a number of larger cysts, varying in size from that of a hickory nut to the dimensions of a large orange. Like the ovarian tumor, the contents of the cyst varied from the color of light yellow serum to the brown color of coffee decoction, and like the ovarian tumor, the consistency of the liquid was somewhat mucilaginous or viscid. In the cut, the arrows (*d. d.*) point to the fibrous portions of the tumor; *a. a.* to the larger cysts; *b. b.* to large cysts emptied and tied; and *c. c.* to some of the cysts of smaller size.

In connection with this case, a few thoughts present themselves which may not be unworthy of mention. Why should a tumor of the neck be allowed to grow to such enormous proportions, as in this case, when the dangers and difficulties of its extirpation are constantly augmenting? Doubtless in some instances, want of proper knowledge on the part of medical counsellors, leads them to advise delay, because of an exaggerated estimate of the dangers of surgery of the neck. In other instances there is reason to fear a want of confidence in himself to give the proper remedy, is coupled with an unwillingness in the family attendant that his patient shall have relief at the hands of another. When it is considered that these tumors ordinarily are somewhat superficial in their early stages, and prone, as they advance, to strike deeply down amongst important nerves and vessels, it seems scarcely probable that a patient before whom the facts were fairly put, would deliberately carry, month by month, and year by year, a tumor which must eventually be extirpated, and this at a constantly increasing hazard. Next to the skilled physician who cures his malady, a grateful patient will always hold in kindly remembrance the faithful monitor who points out his danger, and directs him to the competent specialist who removes it.

I have designated this tumor fibro-cystic, for such it seems to me to be, although it is certainly very closely allied to the "congenital cystic tumor" of Gross, and is probably identical with the rare form of admixture of fluid and solid material, which he mentions as characterizing a case of his own, and one reported by Otto. In this instance, however, I have, on careful inquiry, failed to elicit any information which would lead to the belief that the tumor was congenital. The patient asserts unequivocally that he was twenty-seven years old when he first noticed the growth, and that it was then but a mere marble in size. And more than this, by one of those very common but nevertheless strange coincidences which are so frequently observed in medicine as well as in surgery, scarce a month elapsed from the discharge of Mr. Keen when another man of middle age, from the State of Alabama. presents himself for operation, with a large tumor of the neck, differing apparently from the former one only in the two points of its somewhat smaller size and its situation upon the opposite side of the neck. So clear do I esteem the case, I do not hesitate to pronounce it to be a fibro-cystic growth of the same character as the other. The history given is that it first appeared at about forty years of age, and upon the lower jaw instead of under it. It seems to me that it may be fairly asserted in these two cases, that the disease is not congenital.

An attempt was made in the operation to expedite matters by using the handle of a scalpel to enucleate the tumor, it, however, proved to be wholly unavailing, as the attachments were so intimate and so firm everywhere that perseverance with this instrument would quickly have resulted in a general rupture of the cyst walls, and such inextricable confusion as must have ended in humiliating defeat. By raising the tissues upon a grooved director in small portions at a time, and severing them with scissors close down to the boundaries of the tumor, the latter was kept in full view throughout, and the whole operation proceeded with system and satisfaction. Care was used in the formation of the flaps to place the line of union as accurately as possible in the cervico-maxillary groove so as to hide the cicatrix from front view. The success of this is well shown by the photograph from which Cut III is taken.

RADICAL CURE
OF
STRANGULATED INGUINAL HERNIA.

REPORTED BY
Isaac Smith, Jr., M. A., M. D.,
FALL RIVER, Mass.

A few weeks since, I was consulted by a surgeon in regard to a retained ligature. The case, resulting so well, I think should be recorded. Six months ago a man in middle life had his hernia, which was an old one, strangulated; a number of unprofessional persons attempted its reduction unsuccessfully: finally, surgeons were called. They thought there was little chance of life, but, concluded to operate, which they did in the following manner: The sac was freely opened, and the intestine returned to the abdomen; the sac being gangrenous, they dissected it out without injury to the testis or its appendages, and applied a heavy silk ligature, improvised for the occasion of several strands of ordinary suture silk, close to the abdominal ring; and cut away all exterior to the ligature. The patient made a good recovery without the slightest untoward symptom, and, for the past five months, has done his usual work, laboring, and constantly lifting heavy articles. The ligature had not, at the time my opinion was sought, been removed, and caused some irritation to the skin around it. He has not worn any artificial support since the operation. My advice was to cut down upon and remove the ligature.

Fall River, Mass., December 9, 1876.

PROGRESS OF SURGERY.

Report on Syphilis and Venereal Diseases,

BY

R. W. Taylor, M. D.,

Professor of Diseases of the Skin in the University of Vermont; Physician to Charity Hospital, New York.

TREATMENT OF SYPHILIS.

It is intended that this report, which will appear semi-annually, shall be especially practical in character and only those articles will be analyzed therein which contain facts interesting and important to the general physician and surgeon. The more important communications on the treatment of syphilis, published within a year, have been those relating to the hypodermic method with some mercurial salt. It is well-known that this plan was first employed and largely recommended by Lewin, of Berlin, and soon after by Liegois in Paris, though others had previously used it on a small scale. These observers used the bichloride of mercury in solution, and this preparation is the one which has been most generally used in various countries until of late. As the bichloride of mercury sometimes causes irritation and inflammation of the integument, observers have sought to find other less irritating preparations, as well as those which undergo assimilation more readily. Staub, of Strausbourg, as early as 1871, proposed a chloro-albuminate of mercury in place of the corrosive sublimate, and claimed for this agent, that it was most readily assimilated, less injurious to the tissues, and that it could be used in a much more concentrated solution than any other preparation, the latter quality being a most important advantage. For various reasons this modification of hypodermic medication in syphilis did not attract much attention, and it almost had passed out of mind until the recent publication of Prof. Von Bamberger of Vienna—*Zeit. d. Oest. Ap. Ver.*, 1876, 147, 177. *Vierteljahr fur Derm. und Syphilis and New Remedies*—who has published two articles on the soluble albuminate of mercury for hypodermic use in syphilis. This observer really adds nothing new to our knowledge of this treatment, for his communications are interesting simply as containing minute directions as to how the mercurial salt is prepared, and also as advancing again claims already made. His papers contains a great deal of rather complex detail as to the manner of preparing the soluble albuminate of mercury. This compound is insoluble in water, but is, when fresh, readily dissolved by a moderately concentrated solution of sodium chloride. Such a solution has a neutral and very faint alkaline reaction, and behaves towards nitric acid and tannin potassium ferro-cyanide, alcohol, and heat exactly as a solution of ordinary serum albumen but acetic and tribasic phosphoric acid precipitate it completely.* If a solution of mercuric chloride (corrosive sublimate) be added to an albuminous liquid, mercuric albuminate is thrown down; on transferring this to a filter, allowing to drain and washing, it will be found to be much less soluble in solution of sodium chloride; indeed the diminution of solubility is in direct ratio to the amount of exposure and washing of the precipitate. The usual albuminous fluids when precipitated with an insufficient quality of mercuric chloride, still show traces of mercury in the filtrate, owing to the fact that the small quantity of accompanying chloride keeps some of the mercuric albuminate in solution. Without entering into a detail of the various preliminary experiments, it will be sufficient to state here, that it was necessary to prepare a solution absolutely free from mercuric chloride, and at the same time of such a strength in mercuric albuminate as would be most convenient for various degrees of dilution. The first point to be attended to is the preparation of a clear solution of albumen. This may be effected by freeing the white of hens' eggs from its membranes, diluting with 1½ parts of water, straining through muslin and then filtering through glass-wool (or through asbestos.) In this manner a clear, or at most slightly opalescent solution is obtained.

The strength of the solution of mercuric albuminate is intended to be 0.010 gm. (0.154 grs. or nearly 1-7 gr.) in 1 cc. (16.3 min.;) and the solution itself is prepared as follows:

To 100 cc. of a filtered solution of white of egg (containing 40 cc. of albumen and 60 cc. of water) there are added 60 cc. of a solution of mercuric chloride (containing 5 per cent., or 3 gm. $HgCl_2$,) and

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* This is not the case with serum albumen.

60 cc. of a solution of sodium chloride (containing 20 per cent., or 12 gm. NaCl;) finally 80 gm. distilled water are added, which brings the bulk of the solution up to 300 gm., containing 0.010 $HgCl_2$ in every cubic-centimetre. [A solution of mercuric albuminate, containing 1-7 gr. in 15 minims—the amount intended for one injection, and calculated upon American weights and measures—would be obtained by adding to 3 fl. oz. of filtered solution of white of egg, (containining 1 1-5 fl. oz. of the latter,) a solution of 41 grains of mercuric chloride in 864 minims of water; to the mixed solutions, containing the precipitated mercuric albuminate, a solution of sodium chloride, measuring 864 minims and containing 164 grs. NaCl is added, and finally enough water to make the bulk of the solution measure 9 fl. oz.]

In regard to the keeping qualities of the solution, Prof. Bamberger had some doubts at first, but found afterwards that samples of the solution which had stood in a heated room during winter had undergone no change. In some cases, however, especially where an excess of albumen had been employed, a small white deposit, chiefly of calomel, was found to have taken place. In such a case it is only necessary to pour off the clear liquid, or to filter, as the real percentage of mercury has not been notably diminished.

In an article published subsequently in the same journal (page 177) Dr. E. W. Hamburger suggests a few modifications which are the results of some experiments made with this preparation. The slowness with which the albumen, even when diluted, passes through the filter, and its opalescence are due to precipitable albumen which should be removed by the careful addition of an acid. To determine the exact quantity of the latter necessary, Prof. Huppert's method is recommended, which is as follows:

The well beaten white of egg is diluted with 1½ volumes of water and strained through muslin. A small quantity of the filtrate is now measured off, diluted to 10 volumes, and quickly filtered through one or more plaited filters. This filtrate is still somewhat muddy. Measured portions of this, say 10 cc., are placed into test-tubes, and to each in succession is added dilute 0.1 per cent. hydrochloric acid, increasing by a fixed measure for each test-tube—*e. g.*, 0.1 cc. in No. 1., 0.2 cc. in No. 2., 0.3 cc. in No. 3, etc. It will be found that the opalescence in most of these tubes will be stronger than in the unacidified liquid. This opalescence increases in the various tubes in proportion to the acid added to a certain point, from which it again decreases, and finally, when too much acid has been added, it disappears altogether. The portion which has the most decided opalescence and the most copious flaky precipitate determines the proper quantity of acid. Supposing 0.2 cc. of acid had been used to produce the first appearance of clouding, and 1 cc. had afterwards been consumed until it had become again clear, that portion to which 0.6 cc. of acid was added would then show the largest precipitate. The original white of egg solution is now measured without further dilution, and to every 10 volumes of it the ascertained quantity (0.6 cc.) of a 1 per cent. (that is 10 times as concentrated) acid is added. This liquid now may be filtered rapidly and perfectly clear. To the filtrate is added an equivalent amount of sodic carbonate whereby the alkaline reaction is restored.

Another difficulty occurs in the precipitation of the albumen by corrosive sublimate. It being important to precipitate the albumen as nearly as possible, without however introducing even a trace of an excess of corrosive sublimate, a method of control is necessary. For this purpose, the author recommends sodium carbonate. A drop of the mixture containing the mercuric albuminate in suspension is introduced into a solution of sodium carbonate (or a drop of the former placed upon a few drops of the latter on a glass plate) and the precipitate will remain white, as long as corrosive sublimate is not present in excess. When the latter is the case, the color of the precipitate will be immediately yellow, reddish, or brown. A small portion of the albumen solution is triturated with a corrosive sublimate solution of known strength, and the exact saturating point determined. In carrying out the subsequent precipitation, the sublimate solution is added 0.2 cc, short.—*Zeit. d. Oest. Ap. Ver.*, 1876, 147, 177.

By a later communication (*Pharm. Zeit and New Remedies*,) we learn that the difficulty of preparing a clear and stable solution of the albuminate of mercury, has led Bamberger to replace the albumen by peptone. This latter body is easily soluble in water, resists the effects of heat, alkalies and salts, may be easily filtered, and forms a compound with mercury without difficulty. To prepare the latter, it is necessary to first make a solution of mercuric chloride (corrosive sublimate) of exactly five per cent., and a solution of sodium chloride of twenty per cent., one gramme of meat-peptone is dissolved in 50 cc. of water, and 20 cc. of the mercuric chloride solution are added. This produces a cloudiness, which is removed by the further addition of 15–16 cc. of the sodium chloride solution. The finished liquid contains one per cent of mercuric peptone. The results of all trials which have thus far been made with this preparation are very satisfactory.

The advances thus made in the treatment of syphilis are, that in place of the bichloride of mercury, and calomel, we have a soluble salt of mercury much less liable to produce local iritation; fully as rapid, if not more so, in its effects, and certainly more readily assimilable in the circulation than any other. It is, however, but just to Staub, to give him the credit of having first proposed the preparation.

Neumann has also studied the effects of the hypodermic injections of the albumate of mercury in the treatment of syphilis, and has presented his conclusions in a paper read before the Imperial Academy of Medicine, of Vienna. Though containing nothing really new, the paper is of importance, as it contains the experience of the author, which has led him to endorse the method and the peculiar preparation lately proposed by Bamberger. He states that, to be absorbed into the circulation, mercury is, in the stomach, converted into an albuminate, hence this is the most appropriate form of administration. Bamberger's solution, then, enters the economy without any further change, and the salt is immediately assimilated, without altering the tissues. When rapid action is therefore required, the result is especially beneficial, and constitutes a real advantage to the treatment. Besides this paramount benefit, Neumann has also found that the disadvantages incident to the administration of mercury subcutaneously, are, by this combination, reduced to a minimum, if, indeed, they may be said to exist, as he has found very little, if any local reaction, and no abscesses or gangrene. There are not to be observed those painful, long-lasting indurations, which so often follow certain other mercurial salts. Stomatitis is very rare, and in Neumann's practice, he has not found these systemic troubles, spoken of by some, such as elevation of temperature, colliquative diarrhœa, and frequency of pulse. He also calls attention to the fact that the dose is under such careful regulation. The author also gives a brief historical sketch of the mode of treatment.

Still later, we have the communication of Grünfeld, (*Wiener Med. Presse, No. 38, 1876,*) who has used Bamberger's solution upon dispensary patients with syphilis. He injected daily, 1 gm. of the solution (0.01 Hydralb.) The pain and induration were slight, and disappeared quickly, and no abscesses were observed. He prefers the albuminate of mercury to the corrosive chloride by the hypodermic method. Such is a brief sketch of the progress made, until January, 1877, in the use of this remedy; we will now consider two communications upon the hypodermic use of the bicyanide of mercury in syphilis.

Sigmund, in his first experiments, used a solution of four grains of bicyanide of mercury to an ounce and four scruples of distilled water, and later increased it to five grains. Of this solution, he injected twelve drops daily, which contained about one-tenth of a grain of the mercuric salt. For a cure, which of course simply means the disappearance of certain symptoms or lesions then present, he found it necessary to use from twelve to twenty nine injections, extending on an average, allowing for various interruptions, twenty five days, in which as a rule the patient received from two to three grains of the mercurial. In his later cases, having grown more familiar with the action of the remedy, he used only seventeen injections. There was very little local reaction at the infected points, no inflammation or abcesses, and the resulting indications, which, when corrosive sublimate is used, even with skill and care, are sometimes very persistent, were distinctly limited, and usually underwent absorption in about eight days. The site selected for these injections was the lateral and latero-anterior portions of the trunk, from below the axilla to the crest of the ilium. On this space he made three rows of injections of eight each, and then was able in certain cases to make others there also, if necessary. In thus selecting the site, care must be taken as to the occupation of the patient, and inquiry must be made as to the side of the body on which he sleeps. As a rule, Sigmund enforced rest after the injections, but he says that moderate motion of the trunk might take place without any serious result. The effects of the remedy upon the mouth were very slight indeed, and confined to a moderate reddening of the gums. The general condition of the patient was improved, for, together with the treatment, attention was paid to hygiene and diet. The mouth was also washed frequently with detergent lotions. Sigmund notes the fact, that mercury was to be found in the urine at an earlier period in using this salt, than in those taking the bichloride.

The action of the bicyanide consists in the shortening of the course of simple and mild forms of the second stage (papules, pustules, et cet.) and in the alleviation or improvement of the more complicated and serious forms of tertiary lesions, such as gummy infiltrations. The maculations were more obstinate than other secondary affections, and the infiltrations of the mucus membrane of the mouth, pharynx and tonsils were only slowly acted upon, requiring, as indeed is the case with internal treatment, simultaneous local applications. The late tubercular and ulcerating syphilides became improved under the use of the injections, but were not cured. In such case it remains for the physician to determine, by the progress of the case, whether it is well to persist in the use of the injections. All things being considered, Sigmund is led to think that the bicyanide is less efficacious than the bichloride of mercury, which again is inferior to blue ointment, by inunction. However, he places, as to smallness of dose, rapidity of action, and beneficial results, the injection of calomel, as recommended by Scarenzio, in the first rank, and he thinks that this agent can be used, due care being taken in its administration, without any bad effects whatever, such as induration, abcesses, etc. He thinks that long, careful periods of observation are necessary, in order that we may arrive at conclusions as to the merits of any treatment, and that as yet our knowledge of the action of the injections is in a rudimentary stage.

The injections of the bicyanide of mercury have also been used by Kroworzynski (*Preglad Uharki, Krakowski and Vierteljahr fur Derm. und Syphilis, Heft 2, 1876,*) in the early forms of syphilis, erythematous and papular. Five cases of distinctly commencing had chancre and five cases presenting later syphilitic lesions were thus treated by K, who used a solution of the same strength and in about the same doses as were employed by Sigmund. Kroworzynski concludes that the bicyanide is much more suitable for subcutaneous administration than the bichloride of mercury is, as it causes less pain, the resulting in durations are slighter, more ephemeral, and no inflammation or abcesses follow. Further than this, he did not in his cases observe ptyalism or stomatitis. Dawosky, (*Memorabilien, No. 10, 1876.*) thinks that energetic treatment is, as a rule, contra-indicated in pregnant women, but that the treatment of syphilis should be considered an exception. He recommends the inunction cure, used actively but judiciously, avoiding salivation, and that co-incidently, iodide of potassium should be given internally.

Within two years, a new anti-syphilitic remedy, the tincture tayuya, has been proposed, and recently two articles detailing its use and effects, have been published, (*Gazetta Med. Ital. Lombard, Nov. 25, 1876; Giornale Ital. delle mal Ven e delle Pelle, Oct., 1876; and Chicago Med. Journal, for January, 1877.*) The first article by Longhi, begins with the details of two cases which were not syphilitic; the third observation of the author concerned the case of a child three months old, who had been suckled by a nurse after the latter had been infected with syphilis by a former nursling. The infant exhibited over the groin and external genitalia, ten or twelve papules, of the size of large peas, rounded in contour, and covered with a whitish offensive secretion—these lesions being implanted upon an integument which was considerably reddened. Upon the lips of the mouth were several small, whitish ulcers with reddened borders. Similar sores were also found upon the tongue. The diagnosis was made of papular syphilis of the genitals and mouth. Three teaspoonfuls daily were given of a solution containing one hundred and fifty drops of the dilute tincture of tayuya (Ubicini Brothers) in eight hundred grammes of water. The parts were bathed three or four times daily in the same solution. In a fortnight, the cure was complete, the author expressing a regret that he could not have tested the treatment further, and have made continued observation of the case.

The fourth case of the series is that of a patient thirty-six years old, who had had repeated attacks of gonorrhœa, and a gleety discharge for fifteen years. During this period he had suffered frequently from articular and muscular pains, which were accompanied by swellings upon the manubrium of the sternum, the occipital and parietal bones, the dorsal vertebræ, and ribs. There had been also copper-colored blotches of the surface—one upon the left pectoral region being as large as the hand of an adult. He had vainly tried many kinds of empirical treatment, not neglecting the use of mercury, iodine, hot baths, etc. On the first of September he could hardly move in bed; the lateral movements of the neck were evidently accomplished only with difficulty, and all sudden motions, (sneezing, coughing, etc.,) were excessively painful. The bones were enlarged, as described above; while the eruption and gleety discharge observed did not seem of recent development. A diagnosis was established of macular syphilide, with syphilitic periostitis and arthritis. For several preceding months the patient had taken no medicine; but in July he had been subjected to a hydrotherapy, which left him in a more unfavorable condition than at first. On the 12th of September the treatment by tayuya was begun, in doses of fifteen drops of the dilute tincture in two hundred grammes of water. In five days the patient could tolerate forty drops in the same quantity, which were continued till September 20th. On that day he took eighteen drops of the mother tincture, increased to forty of the same by October 1st, then slight abdominal pain was complained of, when but thirty-five drops of the strong tincture were ordered to be employed. The patient had now for several days stated that his pains were by no means as severe as they were formerly; the osseous enlargments had well nigh disappeared, and also the cutaneous maculæ, with the exception of that upon the breast, which was smaller by two-thirds than at the beginning of treatment; the gleet had completely disappeared. Some recurrence of pain occurred after drinking half a litre of wine with his companions, when the dose was again increased to forty drops. On October 5th. commercial tincture was substituted for that employed, in eighty drops daily, (the mother tincture being exhausted,) and the latter dose gradually reduced to fifty drops by November 10th, the date of the writer's last observation. All the osseous enlargements have disappeared; but the pectoral macule is still visible, and the pain only appears for a day after drinking wine, becoming constipated, or on exposure to the cold.

The second article by Galassi gives the experience of the author in Prof. Gamberinis service in Bologna, in three cases of early secondary syphilis in which the tincture acted well. He also speaks of a severe case of scrofulous inflammation of the face, which was also cured by it.

Dr. Monti, (*Jahrbuch fur Kinderheilkunde, B ix Heft 3, 1876,*) thinks that saccharated iodide of iron is preferable to mercury in the treatment of hereditary syphilis, as it does not, like that metal, produce anæmia, though in its action it is slower than that agent. It is given in the form of powder dissolved in milk, and does not irritate the stomach, and seems to render children comfortable. The specific infiltrations undergo retrograde metamorphosis through its use. The average length of time of cure is twenty-two days, in some cases however it is between ten and thirty days. Monti claims that the nutrition of these children is much improved by taking the iodide but that it does not prevent relapses, although it may render them milder than if mercury is used. He says, however, that it is not beneficial in severe cases. The probabilities are strong that the remedy has no specific action whatever, such as mercury has, and that it is only beneficial as a tonic; the admission of the author of its want of power in preventing relapses and of its failure in seven cases is very significant, and warrants the suspicion that its sphere of usefulness is very limited, and that it offers no exceptional advantage over other ferruginous preparations.

Weisflog (*Virchow's Archiv Band 26, Heft 3*) recommends in cases of gangrenous and phagedenic ulcers the faradic bath for the relief of pain. One of the electrodes at its minimum is to be placed at the bottom of the vessel which contains warm water. The wound is then to be immersed, after which the patient grasps the other electrode, which covered with sponge lies near him, with the point of one finger. When the patient feels that the wound will bear an increase of the current he places one finger point after another upon the sponge, or he draws them back as his sensations indicate. Where the immersion of the wound is impracticable, the nerves in anatomical connection therewith are to be faradized by gently brushing the region in which they run with one sponge electrode, whilst the patient himself regulates the intensity of current by touching the other electrode. As patients readily accustom themselves to prevent muscular contractions in the neighborhood of the ulcers, we can soon, without difficulty, leave the repetition of the applications to themselves. The general treatment is to be followed in the interval. The pains return again soon after each faradization so that in the first days the patients are compelled to resort to the electricity. They however are much less intense than before, and the intervals between them gradually become longer. After the lapse of eight or ten days, these ulcers are not more hyperæsthetic than any other form of ulcers, and they are not altered at all in appearance. The best application at this stage is the ointment of nitrate of mercury, (one to fifty or sixty.) If osteocopic pains are present the same remedy is to be used by subcutaneous injection once only in fourteen days. (*Sic. Rep.*) The author thinks that more frequent application would lead to salivation, (?) which is not necessary to the cure. It seems very probable that this treatment would also be especially beneficial in old, irritable ulcers of the leg. Recent experience has shown the value of electricity in the treatment of atonic ulcers. (*Rep.*)

Hofmeister (*Med. Chir. Remdschau, Dec., 1876*) advocates a combination treatment of cold water and inunctions in syphilis. He thinks that, during the cold water treatment, aliments and medicines are more completely digested and assimilated, and that by this means favorable results are produced by means of a reduced quantity of medicine. Less mercury therefore may be employed in syphilis, and if a cumulative effect is produced it can be readily cast off by the treatment in consequence of the increased excretion and secretion. Furthermore, the regimen indicated in the cold water treatment is such as materially facilitates metamorphosis.

The advantages of the treatment are: (1.) A material gain in time.

(2.) The patient can follow his avocation as he has not to fear the influence of cold. (3.) No ptyalism results, hence there are no interruptions to the treatment.

Vajda (*Ref. d. Vierteljahr 6, Derm. a Syphilis 2 Jahr. 2 Heft.*) makes a communication in which he expresses his preference for oleate of mercury to the mercurial ointment for inunction in syphilis. He found that the general effect was astonishingly rapid and that stomatitis was not developed. The only drawback to the use of the remedy is the appearance of an erythema of the skin. On the other hand another observer, Martini, reports ten per cent. occurrence of stomatitis and a similar proportion of relapses in the use of the cleate of mercury in syphilis.

Guillaumet (*Du traitement des Ulcerations Chroniques Syphilis et cet. Brochure, Paris, 1876,*) having used largely the sulphuret of carbon in chronic ulcers particularly recommends it strongly. He thinks that, as the remedy is not inhaled for a long period, no injurious systemic effects are produced. He obviates its bad smell by combining it with various drugs as follows:

R—Sulphuret carbon, drms. ij.; ess. bitter almonds, gtt. x.

R—Sulph. carbon, drms. ij.; ess. mint, gtt. x to xx.

He has also used it in combination with balsam of Peru, one part of the latter to thirty of the sulphuret of carbon. A mixture of the agent with alcohol alone is unstable and readily separates, but if a little essence of mint is added, this difficulty is overcome. He found that the addition of tincture of iodine with the carbon increased its activity in some cases He used the following formula:

R—Bisulph. carbon, drms. xvi; tinct. iodine, drms. iv.; ess. menth virid, gtt. xvi.

Again R—Carbon sulph. drms. vi.; iodine drm. half.

The strength of the remedy is to be adapted to the indications of the case and condition of the lesions to be treated. The mode of application is by applying the liquid with a brush or with cotton or charpie, which contain only enough to sufficiently saturate, taking care that no flame of light is near by. The brush is lightly and rapidly passed over the surface, which is then dusted with subnitrate of bismuth. Over this a layer of charpie is to be laid smoothly, and the whole should then be carefully bandaged. Should there be much surrounding hyperæmia the author advises a poultice of potatoes or flax seed in the place of the charpie. One application daily is usually sufficient. In some cases this agent cured after iodoform had failed.

HOSPITAL RECORDS.

PENNSYLVANIA HOSPITAL, PHILADELPHIA.

Reported by **JOHN B. ROBERTS, M. D.**, Resident Surgeon.

EXCISION OF THE RECTUM FOR CARCINOMA—SERVICE OF DR. R. J. LEVIS.

The patient, upon whom this formidable operation was performed, was a man sixty years of age, who had had symptoms of rectal trouble for about one year. Digital examination showed that there was a nodulated mass occupying the anterior part of the rectal wall, and extending a short distance to the sides. The finger could easily be hooked over the top of the tumor, which, therefore, extended about two and a-half inches up the bowel. After the bowels had been evacuated by laxatives and an enema, the operation was done as follows: After a large bougie had been introduced into the bladder to serve as a guide to the position of, and also to steady the urethra, an incision was made from the base of the scrotum to the coccyx, encircling both sides of the anal aperture. The hand of the operator was then introduced behind the rectum into the hollow of the sacrum, by which means the bowel was torn loose from its posterior attachments. After this was done, Dr. Levis, by means of his finger and the serrated scissors, broke down the attachment of the viscus around to the front. The cancerous portion was then carefully dissected from the prostate gland and lower part of the bladder, exposing these structures perfectly to view. During these procedures, the vessels were promptly ligated as soon as divided, and double sutures passed through the skin into the rectum above the proposed line of excision. These were not fastened, but left in position in order to give perfect control of the parts.

When the diseased portion had been thoroughly isolated, the gut was drawn forcibly downward by seizing the tumor, and the scissors used to cut through the walls of the bowel. About two and a-half inches were thus excised, leaving behind a perfectly soft and smooth mucous surface. The sutures were then shotted, and a few extra ones applied to keep the gut in position, which was, by this means, securely stitched to the surrounding integument. The parts are washed and dressed with carbolized solutions, and, at present, the patient is doing exceedingly well.

This case reminds me of a case of colotomy done in this hospital a few weeks ago, by Dr. T. G. Morton. The woman, when admitted, had such a tight cancerous stricture, that defecation had been impossible for some time. Colotomy was determined upon, and the colon was opened in the left lumbar region. A most curious complication was the finding of a large cyst, probably renal, lying exactly where the colon was expected, and producing a good deal of displacement of parts, which rendered the operation a very difficult one. The patient, who was a very poor subject, died about two days after the operation.

COLORED HOSPITAL, NEW YORK.

Reported by **WILLIAM KELLEY, M. D**, House Surgeon.

EXTIRPATION OF THE RECTUM FOR CARCINOMA—SERVICE OF DR. C. K. BRIDDON.

Eliza Walker, mulatto, aet. 45. Three years ago the patient complained of pain in the small of her back. During September, 1875, she detected a small, but very painful growth near the anus, which increased till it became as large as a half-dollar piece. There was considerable tenesmus, with frequent desire to urinate, and a constant sensation of burning pain in the rectum, which was increased by defecation. The outside growth was removed about six weeks before admission. The patient entered the hospital August 11th, 1876. On examination, an irregular mass could be felt through the posterior wall of the vagina, and, upon rectal exploration, a slightly prominent nodular growth was found, which encircled the gut, and extended from the external sphincter upward, for an inch and a-half. The rectum was freely movable, and its calibre was but little reduced in size. On examining the patient a month after admission, the mass was found to have extended upward an inch, making in all two and one-half inches.

The operation of extirpation of the rectum was performed on November 20th, 1876. There was but little change beyond an enlarged lymphatic gland above the mass. The operation consisted in splitting up the anal perineum by an incision which reached from immediately behind the fourchette to the point of the coccyx. The anterior and posterior divisions of this incision were united by carrying the knife along the mucous membrane about one-fourth of an inch above the opening of the anus; loops were then passed through the skin flaps on either side, and through the end of the gut. The insertions of the levator ani were severed by the knife, and the rest of the operation performed with the blunt-pointed scissors and the handle of a scalpel. The separation of the mass from the vagina was readily accomplished, but much difficulty was experienced high up in the concavity of the sacrum Eventually, the intestine was brought down and attached to the skin below by twelve sutures. A microscopical examination of the tumor proved it to be cylindrical epithelial cancer.

After the operation, the patient rallied in a few hours, and appeared very comfortable. Next morning the urine had to be drawn by catheter. The temperature then was 103½°. The inflammatory fever which followed the operation was moderate, and during its entire course the temperature never exceeded 103½°. The patient complained of slight pain, which, after a time, disappeared. She is, at the time of this note, no longer troubled with the excessive pain, so marked a symptom previous to the operation. The stitches, after a few days, were removed, and the gut then gradually retracted, and, between it and the external integument, a pseudo-mucous membrane gradually formed. For the first week she was conscious of the desire to defecate, although she had no control over the act.

In the second week an ischio-rectal abscess formed on the right side. There was a fistulous communication between the gut and integument, which, however, healed in a brief period. A short time after, a new fistulous opening formed, which communicated with the vagina near its perineal junction. This, up to the present time, has not healed.

About six weeks after the operation, there was marked tenderness, redness, heat, and œdema, in the right leg; a firm, tender cord could be felt in the popliteal space occupying the position of the peroneal vein. The swelling, etc., gradually extended up the thigh until the entire limb was affected, and it became about twice the size of the other.

The patient's general condition, in the meantime, has been very good; she no longer complains of the excruciating pains she was subject to before the operation. The bowels move regularly, but the feces are discharged involuntarily.

On examination, a little over two months after the operation, it is found that the end of the index finger can just penetrate the lowest portion of the intestine, which is situated about two inches from the external orifice. A pseudo-mucous membrane exists between the gut and the external sphincter. To the patient's left, and posteriorly, a small, nodular, new growth, about the size of a hickory nut, can be felt. This, however, gives her, as yet, no inconvenience.

REMARKS.—The two cases, above recorded, are interesting and valuable, as being instances of an operation which has been done but a few times in this country. In the first case, it seems to have been successful, though sufficient time has not yet elapsed for us to judge how much benefit it really gave the patient. In the second case, the most prominent symptom of which the patient complained, the constant, excruciating pain, increased by the act of defecation, was entirely removed. In cases of a similar nature, the question might arise whether lumbar colotomy might not be a preferable operation. In the case under consideration, the pain from which the patient suffered seemed to be due to the tumor itself, and was only slightly aggravated by defecation. Lumbar colotomy would not have relieved this, and nothing short of the removal of the cancerous mass would have been of much benefit. Again, though the disease is likely to return, still, if the tumor be completely excised, it will give the patient immunity for a greater or less length of time. On the other hand, the operation is one of more magnitude than lumbar colotomy, exposing the patient to the risks of hemorrhage, peritonitis, and, as occurred in the second case, phlebitis. Besides this, the patient has not so much control over the discharge of fecal matter as if he had an artificial anus in the lumbar region.

The weight of authority seems to be decidedly against the operation. Gross, Erichsen, and Allingham, all emphatically condemn it. Mr. Henry Smith, the author of the article on Cancer of the Rectum, in *Holmes' System of Surgery*, stigmatizes it as "barbarous and unscientific." Notwithstanding this array of evidence, however, results have conclusively shown, and it must be admitted that, in properly selected cases, the procedure is not only justifiable, but is the very best thing that could be done.

The operation was first performed by Lisfranc, and his example was afterwards followed by a number of other surgeons. It then seems to have been almost completely discarded, until within recent years it was revived by Billroth and other German surgeons, in whose hands it appears to have been quite successful. Gross* has the following, "Professor Billroth, of Vienna, in 1868, informed me that he had excised the anus and lower portion of the rectum, upwards of a dozen times, with six deaths soon after the operation. One of his patients survived the operation four years and nine months. He also stated in some clinical remarks, that the late Professor Schuh had had one case of four years, and another of seven years, the former being still alive, and in excellent health. In a remarkable case, in which four inches of the rectum, along with the prostate gland and a portion of the neck of the bladder were removed by Professor Nussbaum, of Munich, life was prolonged three years. In four additional instances, the patients lived in ease and comfort, many months, and even several years, before relapse took place." Dr. B. Howard, in a letter from Vienna, published in the *Medical Record*, Nov. 11th, 1876, speaking of extirpation of the rectum, says: "Of the six cases under my observation, * * * * * four made a good recovery, and did not suffer from involuntary discharge of feces. Of ten previous cases, Professor Billroth tells me four died, and the rest did well."

In this country the operation has not been performed very many times. Dr. George Bushe,† of New York, performed it in 1832, on a man, removing about an inch and a-half of the intestine. The patient continued well for a few months, when the doctor lost sight of him, but some time afterwards he heard, from his wife, that he died, of what she called consumption, seven months after the operation.

The late Professor March,‡ of Albany, removed about an inch of the rectum, from a woman twenty-six years old. Rapid recovery ensued, and when last heard from, six months after the operation, the case was doing well.

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* Gross' System of Surgery, fifth edition, Vol. II, p. 652.

† Bushe on the Rectum, p. 294.

‡ Gross, loc. cit.

CORRESPONDENCE.

44 West Twenty-Seventh Street, Dec. 30, 1876.

Editor Archives of Clinical Surgery:

Dear Sir—I have taken it upon myself to write the accompanying remarks upon a criticism recently appearing in your journal. They are intended to be published in the Archives, if agreeable to you. If not, please return to

Your obedient servant,

J. A. Wyeth.

OBSERVATIONS UPON A CRITICISM.

"A prophet is not without honor, but in his own country and among his own kin," was the conclusion arrived at by one of the most remarkable men that ever practiced the art of healing the sick; a man who by the earnestness of his life, the persistent audacity with which he exposed the fallacies of old and accepted ideas, and the intensity of his devotion in advocating a moral revolution, not only succeeded in impressing his peculiar views upon the time in which he lived, but left a name that is the synonym of all that is noblest in humanity, even after the lapse of nearly two thousand years.

Revolutionists in surgery, no less than in morals, politics or religion, asserting new and radical doctrines, suffer in their persons as their motives and principles are attacked, and history tells us they find more thorns than roses in their lives. But they have a great way of living after they are dead, when the principles for which they have struggled are founded upon the firm footing of successful truth.

Notwithstanding the adverse opinion of a long and well studied criticism in a late number of your creditable journal, I think no one acquainted with the vast experience, and the great success which has attended the labors of the author of "Lectures on Orthopædic Surgery and Diseases of the Joints," will doubt that these lectures are great truths and must endure.

The disappointment expressed by your reviewer, I think, results from his misconception of the character and intentions of the author, originating in his lack of information upon the circumstances under which these lectures were delivered, and possibly his neglect to read the preface.

Restricted to forty hours in the course of the Winter session to teach, clinically, the hard sense and practical points in the treatment of the countless injuries embraced in his department, it is scarcely to be supposed that the author would take the time, not justly his, to enter into a full discussion of the morbid anatomy and pathology of each affection, much less that he should give the pedigree of every writer on orthopædic surgery, or the host of instruments that have been devised in the treatment of diseases of the joints. Having selected the instruments of others, or changing them to suit his peculiar views, or originating them himself, and having proved them to have met fully the requirements in this class of injuries, it is but natural to suppose he would dwell with more earnestness to impress their utility upon the minds of the host of students who have listened to these lectures.

It is difficult to refrain from thinking that the reviewer is writing under the impression and influence of personal injustice, for he says: "Contemporary with Davis, Taylor, Bauer, and others, who have done so much for the practical advancement of orthopraxy, * * * we were led to expect a work from Prof. Sayre, which would do full justice to his associates, and which would be especially comprehensive in relation to the pathology of joint diseases." And a few lines further, he repeats, "and the absence of a spirit that would do full justice to the claims of others, will detract from its value and reputation."

In this matter of "full justice to others," perhaps I do not grasp your writer's idea, but I find in the course of twenty-nine lectures, mention and credit given to about one hundred and twenty-nine different medical gentlemen, repeated three hundred and sixteen times, or an average of about eleven to each lecture. An acquaintance with the author, as a student and practitioner, for some years, gives me good ground for assuring your writer that Dr. Sayre is not in the habit of "damning with faint praise." He generally damns in round and unmistakable English, when the occasion demands.

As to Dr. Davis, the author says, (page 260,) "I never succeeded to my satisfaction in my efforts to attain this desideratum until Dr. H. G. Davis, of this city, applied to one of my cases an instrument which he had devised, that answered the purpose admirably, and in its construction embraced the very principles which I had so long sought to apply."

The writer takes issue with the author, who says, (page 261,) "Dr.

Davis since that time has taken out a patent on his instrument." The reviewer remarks, "this is incorrect," and then quotes from Dr. Davis as follows: "This led me to devise and have made, machinery, by which *each part* would be applicable to every splint of the kind. As this was attended with considerable expense, *I patented this mode of manufacturing them.*" In other words, he did'nt patent the instrument, but the machinery and mode of manufacturing it. I think the impartial reader will be satisfied that Dr. Sayre does "full justice" to Dr. Davis, and that the defence of your reviewer, is a clear case of "whipping the devil around the stump." *

In regard to Dr. Bauer, who fails to get "full justice," a perusal of the evidence on pages 443, 444 and 445, will be of interest.

Dr. Bauer says: "Sayre a few years ago performed this operation, as he alleged with success, although his patient died shortly after with pyæmia. The specimen derived from the case, did not prove the assertion of that gentleman; no cartilaginous covering, synovial lining, or capsular ligament having been formed." The statements of Dr. Doyle, Professors Bush, Flint, Jr., and Willard Parker, which follow, positively contradict the charge of falsehood made by Dr. Bauer, and support the "assertion of that gentleman," *i. e.* Dr. Sayre.

Barwell is accredited in some twenty different places, and the reader is referred to pages 370 and 372, as to expressions of opinion of Dr. Taylor's instruments. Exception is taken that "no mention is made of the fact that Dr. Bryan used the 'Plaster of Paris Jacket' in Bellevue Hospital some time before it was used by Dr. Sayre." The author's language does not convey the idea that he originated the "Jacket dressing." In his report to the American Medical Association, at Philadelphia, Dr. Sayre gives Dr. Bryan full credit for its introduction.—(*N. Y. Med. Journal, Aug., 1876.*)

Myotomy in lateral curvature is historically dealt with by the reviewer, as follows: "Syme, Bishop, Little, Tamplin, Adams, Bigelow, and others, refer to the operation, and generally, only to condemn it." Syme says also: "The operation, therefore, should be banished from respectable practice, and if it survives this merited disgrace, be commuted to those members of the profession, who are base enough to take advantage of their patient's credulity for the sake of gain or unworthy notoriety."

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* [Dr. Wyeth here appends a "Synopsis of Specification," No. 35.303, in regard to extension splints, received from the Patent Office at Washington, in which one of Dr. Davis splints is accurately described. It ends with the following:

CLAIM: The within described splint, composed of the tube A, threaded part B, and nut or equivalent, C, as a new article of surgical apparatus; the same being adapted to operate in the manner and so as to realize the advantages herein set forth. (Signed) H. G. Davis.—ED.]

Mr. Syme is high authority, and deserves to be cherished in the memory of the profession to which he gave so much of life and labor, but the infallibility of his judgment is open to doubt, if we remember he says, "if the head of the femur be carious, the patient *must die.*"

Of fifty-nine cases operated upon by Dr. Sayre, caries or necrosis, to the extent of loss of the head of the femur, existed in all, and the acetabulum was perforated or involved in the disease in twenty. Thirty-nine of these fifty-nine are still living, some of them being operated on from ten to twenty years ago, and only eight died from the effects of the operation. This result may not be in accordance with Mr. Syme, though it seems to meet with the approval of the Creator.

Your reviewer etymological, says that "Dr. Sayre, following the error of Bauer, derives, orthopedic, from *orthos*, straight, and *paideuo*, I educate. Audry, the father of the word, gives the second radix '*paidion*' a child." I hold that Dr. Sayre or Dr. Bauer, had just as much right to "father" a word as Audry. It is not a matter of great moment whether the term has been twisted out of *orthos* and *pedion*, the tarsus, or not, so it is accepted as applied to all deformities.

In his corrections of Dr. Sayre as to dates, precedents, etc., the reviewer certainly deserves credit, which the author will doubtless accord to him, in future editions of his lectures, if satisfied that these corrections are correct. It is a matter of regret that your writer lost both his temper and judgment, in his two concluding paragraphs, where he steps outside the limits of the generally accepted idea of professional courtesy, and imputes motives to the author which do not deserve consideration.

In conclusion, I have been highly gratified at the justly critical and dignified reviews of these lectures, by some dozen American journals it has been my fortune to read, among them the *American Journal of the Medical Sciences*, the *New York Medical*, the *Atlanta Medical*, and the *Richmond and Louisville Medical Journals*, all of which I commend to the bibliographical writer of the ARCHIVES OF SURGERY.

Your obedient servant, JNO. A. WYETH.

In his "Observations upon a Criticism," Dr. Wyeth takes issue with us upon some of the minor points of our review of Dr. Sayre's work, on "Orthopædic Surgery and Diseases of the Joints," and has ignored others which are of greater importance. He has not, however, shaken our conviction that our criticisms were just. We certainly should not be blamed for the attitude in which the author places himself; nor for the fact that he ignores alike persons and dates. Before giving his work to the profession, Prof. Sayre should have bestowed sufficient attention to it, to have rendered it, so far as it goes, an authority upon the subjects of which he treats. That he did not do so is a fact, for which we are in no way responsible, and which no prefatory remarks can excuse.

We feel obliged to take exception to Dr. Wyeth's introductory remarks, and the inferences that are unavoidably drawn from them. We submit that Dr. Sayre is not a "revolutionist" in surgery, and certainly not in the sense that the Son of God, whose saying opens the first paragraph, was a "revolutionist" in religion. Perhaps we cannot do better in this connection, than to quote from one of the "justly critical and dignified reviews," to which Dr. Wyeth refers us in the last paragraph of his "Observations." "We have, perhaps, not been sufficiently impressed with the 'new truths' or 'peculiar views of the author,' (Dr. Sayre,) 'for we find those set forth most prominently in this book, scattered through the surgical literature of the last half century." (*New York Medical Journal, Aug. 1876, p. 204.*) This "justly critical" remark is very appropriate. It implies that there is no novel suggestion of importance in the whole of Dr. Sayre's work, and that its author has furnished the profession a compilation, rather than an original treatise. We again express our regret that the author has not awarded "full justice" to the sources from which he obtained his information, and tender thanks to our critic for such an excellent reference.

Regarding the origin and radices of the word *orthopædy*, we admit that Dr. Sayre has a perfect right to "father" any word he may invent for the purpose of expressing a definite idea. But this word he did not invent, and, moreover, he states, (p. 3) that Audry "adopted this comprehensive appellation, *orthopædy*, from *orthos*, straight, and *paideuo*, I educate," which is not so, and hence our criticism. We may apply the same remarks to other and more important matters than a mere word. For instance, Dr. Sayre says, (p. 270) "I more commonly employ the long splint, which is a modification of that devised by Dr. C. F. Taylor;" (we mention this "modification" in our review,) on p. 282 we find the following, (the italics are ours,) "I applied to her one of *my long splints*, with abducting and rotating screws." Again, on p. 292, when speaking of "the wire cuirass," (Bauer's wire breeches,) he says, "This instrument is a modification of Bonnet's *grand appariel*," wholly ignoring Dr. Bauer. He also ignores Dr. Bryan, and permits the inference that he (Dr. Sayre) was responsible for the introduction of the "plaster jacket." It is this tendency to "father" things, (we again express our obligations to our critic,) to which we refer, when we speak of Dr. Sayre's failure to "do full justice to the claims of others," our idea of which, Dr. Wyeth certainly does not "grasp."

The disappointment and regret which we express, arise from the fact, that while sufficient time and trouble are taken to add to the lectures quite a number of hospital and private cases, some of which had been previously published, no effort was made to render the work a comprehensive one, pathologically. We certainly intimate that we read the preface, for we refer, in the last paragraph of our review, to the "professedly extemporaneous character of the *lectures*."

Regarding Dr. Davis and the patent upon his splint, we would simply state that we wrote to him regarding the matter. A portion of his reply was incorporated in our review. We made our statement in good faith and upon the authority of Dr. Davis. We cannot be held responsible for any misstatements he may have made. We can only acknowledge cheerfully that had our letter of inquiry been addressed to the Patent Office, instead of to Dr. Davis, we should have made no comment whatever upon Dr. Sayre's criticism of Dr. Davis.

On page 372 of Dr. Sayre's work will be found the following, when the author introduces the subject of the use of the gypsum bandage in the treatment of "Pott's disease." "The thought had occurred to me that this might be done, but I had hesitated, through fear that respiration would not be properly sustained if the child were completely enveloped in such a fixed apparatus." Dr. Wyeth says, "The author's language does not convey the idea that he originated the plaster dressing," and that "in his report to the American Medical Association at Philadelphia, Dr. Sayre gives full credit to Dr. Bryan for its introduction." We are at a loss to understand what impression Dr. Sayre wishes to convey in the first quotation unless it be that his thought was an original one—nor can we comprehend why he should have neglected to do Dr. Bryan "full justice" until several months after his work appeared.*

We have not asserted that Mr. Syme is infallible. We know, however, that he is one of the high authorities that Dr. Sayre quotes, and that he is universally esteemed as an accurate observer. It was therefore with some surprise that we read in Dr. Sayre's work, (page 259,) the following sentence as being quoted from Syme, "If the head of the femur be carious the patient *must die!*" We regret that neither Dr. Sayre, nor Dr. Wyeth, who calls our special attention to it, refers to the article from which this unqualified and emphasized assertion is taken. We have searched diligently for it without success. If, however, he did make this remarkable statement, he certainly afterward changed his opinion. On page 261, of Syme's surgical works, (MacLean, 1866,) we find the following. (The italics are ours.) "When the disease," (morbus coxarius,) "goes on to suppuration *in adults* the case may be considered nearly hopeless, as caries then almost always ensues, and being seated in a part" (*i. e.*, involving the acetabulum) "where excision cannot be performed, inevitably proves fatal to the patient sooner or later. *In children* the chance of recovery is much greater." This statement leaves a very different impression from that produced by the unqualified and italicized sentence upon which Dr. Wyeth bases the fallibility of the Edinburgh professor.

If our review permits the inference that we wrote "under the impression and influence of personal injustice" we are glad that Dr. Wyeth mentioned it, as it gives us the opportunity of asserting that had there existed any ground for personal differences between the author of the lectures and ourselves, we would, when asked to review the work, have peremptorily declined.

Regarding the charge that the reviewer "lost both his temper and judgment," and that he stepped "outside the limits of the generally accepted idea of professional courtesy," we would simply refer those interested, first, to a careful perusal of the work, and then to our review in the October number of the ARCHIVES.

* A letter just received from Dr. Joseph Bryan, now of Lexington, Ky., is accompanied by one of Mason's stereoscopic views, which represents the plaster jacket, as applied by Dr. B. to Rose Brennan, at Bellevue Hospital, in July or August, 1874, for Pott's disease of the first and second lumbar vertebræ. His method of application seems to have been very accurately followed by Dr. Sayre. Dr. Bryan says, "After having fitted a flannel jacket neatly to the surface of the body, and extending from the axilla to the trochanter major, I removed the superincumbent weight from the diseased bones by means of compound pulleys attached to the ceiling of the ward, and to a figure of eight bandage over neck and under axillae, having patient seated on a ward stool. In this position she was free from pain. I then applied the plaster roller around the body and extending from the axilla nearly to trochanter major, so that it would take firm hold of the pelvis." This apparatus was applied in the hospital with which Dr. Sayre is prominently connected, before the course of lectures, which form the basis of his work was commenced. Again we state that we cannot comprehend why Dr. Sayre did not do "full justice" to Dr. Bryan in his work.